STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235477	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pomeroy Living Rochester Skilled Rehabilitation	3500 West South Blvd Rochester Hills, MI 48309

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 34208 Based on observation, interview, and record review, the facility failed to ensure water was provided and kept within resident's reach for one resident, (R33) of one resident reviewed for accommodation of needs. Findings include: On 2/25/25 at 9:39 AM, R33 was observed sleeping in their bed. It was further observed R33 had no water for drinking at their bedside. An observation of their bedside table situated parallel to the bed on the left side revealed a typed note taped to the top that read, PLEASE place this tray table above her abdomen so she can reach her drink! .She is often dehydrated as table & water is out of reach . Further review of the room revealed a chalkboard on the bathroom door that read, Keep my water within my limited reach of Rt (right) hand. On 2/25/25 at 2:32 PM, 2/26/25 at 8:48 AM, 10:05 AM, and 2:30 PM, R33 was observed in their bed. The tray table with water for drinking was observed to the left side of the bed, out of reach from their right hand. A review of R33's care plan was conducted and read, .ADL (activities of daily living)-Decreased ability to self care .Interventions .Keep my call light and my frequently used personal item within my reach. Encourage and remind me to use call light for assistance . On 2/27/25 at 9:02 AM, the observations of R33's water not placed in reach were shared with the Assistant Director of Nursing and they acknowledged the concern. On 2/27/25 at 8:19 AM, a policy regarding accommodation of needs was requested via e-mail, however; it was not provided by the end of the survey.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48680 Based on observation, interview and record review, the facility failed to follow end of life wishes for one of one resident (R417) reviewed for advance directives. Findings include: On [DATE] at 1:43 PM, during and interview, R417 was asked about their end of life wishes. R417 reported, they did not want to receive Cardiopulmonary resuscitation (CPR) because R417 did not want their chest to be cracked open and be placed on a breathing tube. R417 was then asked who was responsible for making medical decisions for them, R417 stated that they would be in control of decision making until they were unable to do so. R417 reported, they signed a paper the day before to become a Do Not Resuscitate (DNR). A review of the record revealed that R417 was admitted to the facility on [DATE] with the diagnoses of depression, anxiety and COVID-19. The most recent Minimum Data Set (MDS) indicated a Brief Interview for Mental Status score of 15, which indicated no cognitive impairments. The record also revealed that R417 was a full code, indicating an attempt of full resuscitation if the resident's heart were to stop beating. On [DATE] at 1:48 PM, Nurse N was interviewed and asked, in the event R417 was to become unresponsive, what would the facility do for them. Nurse N replied that R417 was a full code so they would start CPR. On [DATE] at 3:07 PM, the social work department, Social Work Director AA and Social Services BB was interviewed about the code status of R417 as to why they were still a full code even though R417 requested to become an DNR. Social service BB reported that when they gave R417 the paperwork (to change from a full code to a DNR) they explained that it can take ,d+[DATE] hours to have the physician sign and the status be changed in the medical record. The Social Work Director AA was then asked, why could a verbal order not be taken to honor the resident's wishes. Social Work Director AA reported that it was not in their scope to transcribe verbal orders. Social Work Director AA was asked could the nurse take verbal orders until the physician can physically come in and sign the orders and the Social Work Director AA responded that nurses can take verbal orders but the advanced directives were not done this way, that they would wait the , d+[DATE] hours until the physician came in to change someone's code status. On [DATE] the Director of Clinical Services was interviewed and asked could Nurses take verbal orders from physicians for code status. Director of clinical services explained that the nurses could take verbal orders. A review of the facility's policy Advance Directive Policy dated [DATE] revealed the following: .Do-Not-Resuscitate Order-A do-not-resuscitate (DNR) order is a written document in which the resident expresses their wish that if their breathing and heartbeat cease, they do not want anyone to attempt to resuscitate them .DNRs may .be requested by the resident themselves. Becomes effective upon signature . Procedure: .Complete DNR .Place copies of all paperwork in chart .Review advance directives at least annually . (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No addition information was provided at the exit of survey.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 This citation pertains to intake #MI00148138. Based on observation, interview and record review, the facility failed to follow nursing professional standards of practice related to medication administration for two (R29 and R368) of two residents reviewed for professional standards. Findings include: R29 Review of the clinical record revealed R29 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: type 2 diabetes mellitus with diabetic neuropathy. According to the Minimum Data Set (MDS) assessment dated [DATE], R29 had intact cognition, had orders for insulin and received insulin injections for seven of the last seven days. Review of the physician orders identified R29 was to have their blood sugar (BS) level checked at 7:30 AM and parameters were in place to administer insulin depending on what the BS result was. On 2/26/25 at 9:45 AM, review of R29's Medication Administration Record (MAR) revealed the was no documentation (blank) for if this had been completed as ordered. On 2/26/25 at 9:47 AM, Nurse 'E' who was assigned to R29 was asked about where they documented BS results. Nurse 'E' reported that should be on the MAR. When asked about R29's lack of documentation on the MAR, Nurse 'E' reported they had obtained the resident's BS earlier, but did not document it and further stated, I'll do that right now. When asked when that should be documented, Nurse 'E' reported when it's (the blood sugar) obtained. On 2/26/25 at 12:13 PM, an interview was conducted with the Assistant Director of Nursing (ADON). When asked about the facility's practice for monitoring and documenting BS's for diabetic residents, the ADON reported the physician orders should be followed. The ADON was informed about the concerns with R29 and discussion with Nurse 'E' and they reported the nurse should've documented that immediately. The ADON further reported staff were educated if it was documented, it wasn't completed. The ADON reported the BS's should've been documented at the time it was obtained, in accordance with the physician orders and entered on the MAR. 41415 R368 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/25/25 at 10:19 AM, an interview was conducted with R368 who was observed sitting in a wheelchair in their room. R368 stated they were concerned because the staff had not taken their vital signs yet or administered their blood pressure medications. R368 stated they were concerned because they were having problems with their blood pressure. On 2/25/25 at 10:21 AM, Registered Nurse (RN) D (the assigned nurse for R368) was interviewed and asked how many residents they were responsible for and RN D replied approximately 15 residents. RN D was asked if they were late in administering the resident medications for the morning and RN D stated they were not. RN D was then asked about obtaining R368's blood pressure and the administration of R368's blood pressure medications. RN D then stated that R368's medications are a little late, however RN D stated they would administer the medications to R368 next. A review of the Physician orders and Medication Administration Record (MAR) for February 2025 revealed the following: Nifedipine ER (extended release) 30 mg (milligrams) tablet by oral route once daily for hypertension. This was scheduled for 9:00 AM. Metoprolol Succinate ER 50 mg tablet by oral route once daily for hypertension. This was scheduled for 9:00 AM. A review of the administration times of R368's blood pressure medication revealed the Nifedipine ER was documented as administered at 10:32 AM and the Metoprolol was documented as administered at 10:32 AM. On 2/27/25 at 12:23 PM, the Assistant Director of Nursing (ADON) A (who covered the medical care/questions as the facility's Director of Nursing (DON) was not present for the survey) was interviewed and informed of the interviews with R368 and RN D. ADON A was asked about the normal protocol for medication administration in the facility was and ADON A replied the nurses have an hour before or after (the prescribed time) to administer medications. ADON A stated if the nurse was running late they should have called the doctor to inform them and let management know so that we can help out. No further explanation or documentation was provided by the end of the survey.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 Based on observations, interviews and record reviews the facility failed to consistently provide assistance for oral care for a dependent resident, one (R58) of three residents reviewed for Activities of Daily Living (ADLs). Findings include: On 2/25/25 at 11:00 AM, R58 was observed in the community room playing a game with their daughter. R58 was asked if they had any concerns with the facility's care. R58's daughter replied that their dad always made sure their hygiene was up to par and they had concerns with the staff not assisting R58 with brushing their teeth. R58's daughter explained that R58 can brush their own teeth if staff set up their tooth brush and tooth paste and handed R58 their toothbrush, however staff were not ensuring the assistance was being provided. R58 was asked if staff assisted with brushing their teeth this morning and R58 replied No. A review in the medical record revealed R58 was admitted to the facility on [DATE], with diagnoses that included: traumatic subdural hemorrhage encounter, muscle weakness, and dysphagia. R58 required staff assistance for all ADLs. A review of a care plan titled ADL- Decreased ability to self care included the following intervention, . Provide me assistance for ADL, bathing, toileting, dressing, transferring, grooming, hygiene as needed. Encourage me to participate in self care as I can tolerate . On 2/27/25 at 11:56 AM, R58 was observed sitting in their wheelchair in the community room talking to a peer. R58's teeth was noted to be visibly dirty with plaque. R58 was asked if the staff provided assistance for them to brush their teeth and R58 responded No. R58 confirmed their teeth had not been brushed this morning. On 2/27/25 at 11:58 AM, Certified Nursing Assistant (CNA) P (the CNA assigned to R58) was interviewed and asked why they had not assisted R58 with brushing their teeth this morning and CNA P stated R58 was already up and dressed when they got on duty this morning. CNA P stated since the midnight CNA had gotten R58 up for the day, they assumed the midnight CNA assisted R58 with their oral care. On 2/27/25 at 12:21 PM, the Assistant Director of Nursing (ADON) A (who covered the medical care/questions as the facility's Director of Nursing (DON) was not present for the survey) was interviewed and asked about the responsibility and coordination of care regarding R58's oral care and ADON A responded that R58's oral care should have been completed when they were provided assistance with getting out of bed and dressed for the day. ADON A stated they would follow up on the concern. No further explanation or documentation was provided by the end of the survey.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 This citation pertains to intake #MI00150390. Based on observations, interviews and record reviews the facility failed to timely implement a fungal rash treatment (R372), timely implement treatment for edema (R85) and failed to obtain a physician ordered blood sugar level (R48), for three of 24 sampled residents reviewed for quality of care. Findings include: R372 On 2/25/25 at 12:47 PM, R372 was observed lying on their back in bed. R372's husband was observed sitting by the bedside. When asked about any concerns R372 had, R372's husband explained that R372 was prescribed an ointment in the hospital for a fungal rash that had started on R372's buttocks. R372's husband stated the hospital noted the cream on R372's discharge paperwork however they believed the facility failed to implement the treatment. R372's husband stated they saw the rash yesterday and it worsened and spread to R372's groin area. R372's husband stated they are in the facility every day and all day, except overnight and they had never seen staff apply the cream. R372's husband stated they had informed multiple staff members of the prescribed cream, however no one was listening and expressed their frustration. A review of the medical record revealed R372 was admitted to the facility on [DATE] with diagnosis that included: pneumonia, shortness of breath, diaper dermatitis and required staff assistance for all Activities of Daily Living (ADLs). On 2/26/25 at 9:10 AM, an observation of R372's buttocks and groin area was made with the assistance of the Assistant Director Of Nursing (ADON) A. A red/purplish fungal rash was observed around the anus, left/right buttock and groin area on R372. A review of the hospital discharge documents that was provided to the facility upon R372's admission included the following: . After Visit Summary Start taking . miconazole nitrate (MICATIN) . miconazole nitrate 2% Oint (Ointment). Apply 1 Application topically 2 times daily. Apply to affected area . A review of the admission orders for R372 revealed no implementation of the miconazole nitrate ointment. A review of the medical record revealed no documentation or clarification on why the ointment was not implemented upon admission. A review of the physician orders revealed the Miconazole nitrate cream was ordered on 2/25/25 at 4:22 PM. This is after R372's husband had informed the surveyor of the concern and three days after the resident's admission into the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/25 at 9:03 AM, the facility's Assistant Director of Nursing (ADON) A (who covered the medical care/questions as the facility's Director of Nursing (DON) was not present for the survey) was interviewed and asked why R372's Miconazole Nitrate ointment was not ordered and implemented upon admission as directed by the hospital. The ADON A stated they would look into it. The ADON A was asked if R372's physician at the facility did not agree with the course of treatment and changed the treatment order to another medication would that be documented in the medical record and ADON A stated R372's cream should have been implemented if the hospital noted it on the discharge paperwork. ADON A then stated if the physician did not agree with the course of action it should have been documented in the resident's chart. ADON A stated they would look into it and follow back up. No further explanation or documentation was provided by the end of the survey. 38271 R85 On 2/25/25 at approximately 9:17 a.m., R85 was observed in their room, up in their wheelchair. R85 was queried if they had any concerns with with their care and R85 indicated that their legs were swollen and nobody was doing anything about it. R85's bilateral lower extremities (BLE) were observed to have some swelling. No wraps or compression stockings were observed. R85 was queried if the Nursing staff were wrapping anything on their legs and they reported they were not. On 2/26/25 at approximately 9:02 a.m., R85 was observed in their room, up in their wheelchair. R85 was queried how their legs were feeling and they indicated they were still a little swollen with fluid. R85 was queried if any staff were putting on wraps on their legs and they indicated they were supposed to but that nobody could find them any to put on. On 2/27/25 at approximately 9:47 a.m , R85 was observed in their room, up in their wheelchair. R85 was observed with ACE wraps on their bilateral legs. R85 reported that the wound Nurse had came to their room the last night and put them on for the first time. R85 reported that they had to be at dialysis for an hour longer the previous day to take some excess fluid off. On 2/25/25 the medical record for R85 was reviewed and revealed the following: R85 was initially admitted to the facility on [DATE] and had diagnoses including Chronic kidney disease and Type 2 Diabetes. A review of R85's MDS (minimum data set) with an ARD (assessment reference date) of 2/8/25 revealed R85 needed assistance from facility staff with most of their activities of daily living. R85's BIMS score (brief interview for mental status) was 15 indicating intact cognition. A review of R85's careplan revealed the following: Focus-CARDIAC DISEASES: CHF (Congestive heart failure) .Goals-With the measures put in place my risks for CHF exacerbation will be reduced . Interventions-Assess my location and character edema. Notify my MD (Medical Doctor) as needed. Medical, Nursing Active. Effective: 2/10/2025 Observe me for signs and symptoms of fluid excess such as weight gain, increased blood pressure, full/bounding pulse, jugular vein distention, SOB (shortness of breath), moist cough, rales, rhonchi, wheezing, edema, worsening of edema, increased urinary output, nausea/vomiting, liquid stools. Medical, Nursing. Active Effective: 2/10/2025 . A Nurse Practitioner's note dated 2/21/25 revealed the following: .Complaints and Symptoms (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Patient complains of: Cardiovascular (Central/Peripheral): Edema (4+ edema BLE), Lower extremity (leg) swelling .Physical Exam: Patient has non-palpable pulse to BLE. Patient has 4+ edema to BLE Plan .Elevate BLE above the level of the heart Offload Bilateral Heels Ace Wraps to BLE: on in AM, off in PM (please wrap from toes to knees) . A review of R85's Physician orders revealed the following: Ace Wraps to BLE on in AM, Off in PM; Wrap from toes to knees. Chart refusals. Start date 2/22/25. Frequency noted as on 6:00AM-10:00 AM. Off 8:00PM-11:00PM. A review of R85's Treatment Administration Record (TAR) for February 2025 revealed the days in which R85's Ace Wraps were documented as not applied in the AM as ordered: 2/24, 2/25 and 2/26. On 2/27/25 at approximately 10:24 a.m., Nurse Q was queried regarding R85's swollen legs. and R85's report that staff have not previously been applying the ACE wraps to their legs. Nurse Q reported that the wound care Nurse had put the wraps on the previous night and that they had never put them on R85. Nurse Q indicated they did not know where the ACE wraps were. On 2/27/25 at approximately 2:34 p.m., the ADON (Assistant Director of Nursing) was queried regarding the missing ace wraps for R85. The ADON Stated that they were aware R85 did not have them, because they had only bought four wraps previously and other residents were also in need of them. 30675 R48 On 2/26/25 at 8:44 AM, Nurse 'O' was observed taking a breakfast tray to R48. While delivering the meal tray, R48 asked Nurse 'O' Do you need to check my sugar? Nurse 'O' responded Oh, I'll let the nurse know. Nurse 'O' exited the room and when asked if they were R48's Nurse, they reported they were not, they were the MDS Nurse and reported they would find the nurse. Nurse 'O' proceeded to continue passing other meal trays and was not observed following up with R48's assigned nurse (Nurse 'N'). On 2/26/25 at approximately 8:50 AM, Nurse 'N' was observed exiting a room from further down the unit and upon approach reported they were in the process of passing out breakfast trays. When asked if anyone had let them know about R48's query about blood sugar (BS) check, Nurse 'N' reported they had not. When asked if they had obtained R48's BS level yet this morning, Nurse 'N' reported they did not as they were told they needed to pass out meal trays. On 2/26/25 at 8:52 AM, an interview was conducted with Nurse 'N' who confirmed they were assigned to R48. When asked if they had been informed of R48 wanting their BS checked, they reported they were not and further reported they had not had a chance yet this morning to obtain any BS levels. When asked about when BS monitoring should be completed, Nurse 'N' reported those would normally be done at 8:00 AM, but was told they had to pass meal trays. When asked if they normally delayed their medication administration to pass meal trays, Nurse 'N' reported they did not. Review of the clinical record revealed R48 was initially admitted into the facility on [DATE], readmitted on [DATE] with diagnoses that included: diabetes due to underlying condition with diabetic neuropathy. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the Minimum Data Set (MDS) assessment dated [DATE], R48 had intact cognition, had orders for insulin and received insulin injections for four of the last seven days. Review of the physician orders included orders to administer an insulin medication (Humalog KwikPen) per sliding scale (based on the BS level) and was ordered to be done before meals. The Medication Administration Record (MAR) prompted the nursing staff this was to be done at 7:30 AM, 11:30 AM, and 4:30 PM. Further review of the MAR revealed the section which prompted Nurses to document the dose given and site it was administered was blank on 2/24/25 and 2/25/25. Only the BS results were documented. As of this review on 2/26/25 at 9:26 AM, there were no BS results or documentation this had been completed yet for R48.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on observation, interview, and record review, the facility failed to monitor documented weights and ensure timely nutritional interventions were implemented to prevent significant weight loss for one resident (R23) of four residents reviewed for nutrition, resulting in a 22.94% weight loss from October 30, 2024 to December 2, 2024. Findings include: On 2/25/25 at approximately 10:27 a.m., R23 was observed in their wheelchair in the common area. R23 was observed to be thin and was queried if they had lost any weight and they reported that they had. On 2/25/25 the medical record for R23 was reviewed and revealed the following: R23 was initially admitted to the facility on [DATE] and had diagnoses including Moderate protein-calorie malnutrition and - Chronic kidney disease, stage 3. A review of R23's MDS (minimum data set) with an ARD (assessment reference date of 1/29/25 revealed R23 needed assistance from facility staff with most of their activities of daily living. R23's BIMS score (brief interview for mental status) was 15 indicating intact cognition. R23's recorded weights revealed the following: 10/30/24-148 lbs. 11/6/24-131.8 lbs. (loss of -10.95%) 11/26/24-117.6 lbs. (further loss of -10.77%) 12/2/24-114.05 lbs. (continued loss of -3.02%). A Nutritional assessment dated [DATE] revealed the following: Resident is .admitted s/p (status post) .s/p laparotomy > total colectomy with end ileostomy, .who is on a minced & moist diet, is able to feed herself and has a variable appetite consuming 25-100% of her meals. She has her own teeth (many missing) and SLP (speech pathology) is currently working with her regarding her mechanically altered diet. She usually weighs 140's-150's, her recent weights: 8/28=140.2 lbs., 7/14=141 lbs and her CBW (current body weight) is 148 lbs. She does have BLE (bilateral lower extremity) edema so weight loss is possible with decreasing edema. Her skin is free from pressure ulcers although she does have an ostomy. Resident is at nutritional risk d/t (due to) moderate PCM (protein calorie malnutrition) > temporal, clavicle, deltoid wasting, low po (oral) intake, mechanically altered diet. Will continue to monitor her weight, po intake and labs as avail and will make changes prn (as needed) .Care plan initiated. Further review of the facility's Dietary notes and assessments for the time period between 10/30/24 and 12/3/24 did not reveal any assessments/reviews addressing R23's significant/continued weight loss. (continued on next page)

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	235477	A. Building B. Wing	02/27/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Dietary note dated 12/4/24 revealed the following: CBW (current body weight) 114lbs indicating significant weight loss. Her UBW (usual body weight) used to be ~140-150lbs. Resident's admission weight on 10/25 was 148, 10/27 148, 10/30 148. Then sudden drop in weight was noted on 11/6 at 131.8 and further on 11/27 117.6 and on 12/2 114. When she was readmitted she has BLE (bilateral lower extremity) edema, receiving diuretic for the same which might have contributed in some weight loss. She also hx (history) of c-diff s/p (status post) laparotomy, total colectomy with end ileostomy, a-fib, .She is on a minced & moist diet, is able to feed herself and has a variable appetite consuming 25-100% of her meals. She is receiving Dronabinol which may treat nausea and vomiting caused by chemo (chemotherapy) and help stimulate appetite. Also receiving supplement Medpass 2.0 120cc (cubic centimeters) BID (Reduced sugar) to promote wound healing and d/t (due to) variable meal intake. Skin with chronic unstageable pressure injury to sarcococcyx <sic> . RD (Registered Dietician) encouraged Resident for nutrition and hydration. Recommend to be up for meals in dining area. Resident requested for diet upgrade for which SLP (speech pathology) has been notified. Recommend to increased Medpass supplement (reduced sugar) to 120cc TID (three times a day). Monitor weekly weights. Check labs. Will continue to monitor weight trends, po (oral) intake, labs, skin integrity and follow up as needed . On 2/27/25 at approximately 10:38 a.m., Registered Dietician F (RD F) was interviewed regarding R23's significant weight loss in November 2024. RD F was queried why no dietary assessments or reviews addressing R23's continued weight loss in November was present in the record. RD F was observed reviewing R23's medical record and reported a previous RD was covering the facility at that time and that they had started covering the residents at the end of November 2024. RD F was queried what the process was for residents with identified weight loss and they reported that they review weights every morning for weight loss and if they notice a significant weight loss would evaluate the resident and recommend new nutritional interventions to try to maintain weight. RD F indicated they could not find any assessments or reviews from the dietary department in November 2024 indicating they had reviewed R23's weight loss. RD F reported that they did review R23's nutritional status and weight loss on 12/4/24 (per their progress note in the record) in which they recommended an increase in a nutritional supplement and had requested for their diet to be evaluated for an upgrade by speech pathology. RD F reported that after they had evaluated R23 in early December and their weight was able to be maintained and R23 did not have any further significant weight loss. RD F was queried for any additional documentation that R23's significant weekly weight losses in November 2024 had been reviewed/addressed and they indicated they would look for anything missing. On 2/27/25 a facility document titled Weight Management was reviewed and revealed the following: Residents will be monitored for significant weight change on a regular basis. Residents are expected to maintain acceptable parameters of nutritional status, such as usual body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. Since ideal body weight charts have not yet been validated for the institutionalized elderly, weight loss (or gain) is a guide for determining nutritional status. Therefore, the evaluation of significant weight gain or loss over a specific period is an important part of the assessment process 6. Ensure that each resident identified with significant weight change is on a weekly schedule. 7. Ensure that each resident with significant weight change has a current assessment by the RD . No further documentation was provided by the end of the survey. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included the dietician reviewing weights daily basis and making recommendations for identified weight losses. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 34208 Based on observation, interview, and record review, the facility failed to ensure a medication error rate less than 5% when three medication errors were made for two residents (R#'s 12 and 50) of four residents reviewed during the medication pass observation, resulting in a medication error rate of 10.34%. Findings include: On 2/25/25 at 10:21 AM, Nurse 'U' was observed preparing medications for administration to R12. Nurse 'U' prepared multiple medications including a 10 mg cetrizine (allergy medication) tablet. They said R12 had a 5 mg (milligram) midorine (medication to treat low blood pressure) tablet due at that time and they were going to hold it because R12's blood pressure and heart rate were too low for administration. They reported R12's blood pressure was 115/58 and their heart rate was 58. Nurse 'U' proceeded to R12's room and administered the prepared medications. Upon completion of the administration, Nurse 'U' signed the medications out in the medication administration record. On 2/25/25 at 3:51 PM, a review of R12's physician's orders and medication administration record were reviewed and revealed the midorine medication had no blood pressure or heart rate parameters to indicate the medication should have been held. It was further discovered R12 did not have an order for cetrizine 10 mg, instead they had an order for a similar medication, loratidine 10 mg. On 2/26/25 at 12:53 PM, an interview was conducted with Nurse 'U' regarding their reasoning for holding the midorine medication on 2/25/25. They said it was because R12's systolic blood pressure was below 110, though it was reported and recorded as 115/58 on 2/25/25. They were asked to review the order and confirm the medication had physician ordered parameters to hold the medication. When they reviewed the order they reported there were no instructions to hold the medication and said they would reach out to the Nurse Practitioner to add them. They were then asked about the allergy medication and confirmed they administered 10 mg of cetrizine. They were asked to pull the order for the 10 mg cetrizine and they pulled up an order for Claritin (generic name, loratidine allergy medication). At that time they realized the error between the ordered Claritin (loratidine) and the cetrizine they administered. On 2/27/25 at 9:02 AM, the medication errors observed were shared with the facility's Assistant Director of Nursing (ADON) and they acknowledged the concern. 48680 R50 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/26/25 at 8:25 AM, an observation for medication administration was completed with Nurse E for R50. Nurse E reported that R50 only had one medication due at that time because it was not the window for medications to be administered. Nurse E was asked, why were they administering a nighttime medication in the morning, Nurse E reported, that it was not a night time medication and that they took that medication themselves during the day time as well. Nurse E then prepared one pill Atorvastatin (cholesterol medication recommended to give at nighttime) 40 milligrams(mg). Nurse E entered resident room and stated to the residents here is your vitamin. Nurse E was asked, why did they tell R50 that the medication was a vitamin when it was a cholesterol medication. Nurse E reported, R50's family member requested that they call all medications vitamins so R50 would not refuse. A record review was completed, revealing that R50's medication (Atorvastatin 40mg tablet) was ordered to give one tablet by oral route once daily at bedtime. On 2/26/25 at 12:22 PM, Nurse E was interviewed and shown the medical record. Nurse E was asked why they administered a nighttime medication at 8:25 AM, Nurse E reported, the order was incorrect, and they would reach out to the physician to get the order corrected. On 2/26/25 at 2:05 PM the Assistant Director of Nursing (ADON) and Administrator were present for interview. The ADON was asked should a nighttime medication be given during the day and what the process was for medications that are ordered incorrectly. The ADON reported that the order should have been clarified with physician for the correct time of administration. No additional information was presented by the exit of survey.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 Based on observation, interview, and record review, the facility failed to ensure medications were stored appropriately for one resident (R367) of one resident reviewed for medication storage as well as properly stored, labeled, and dated in five of five medication carts reviewed. Findings include: R367 On 2/25/25 at 12:06 PM, R367 was observed lying on their back in bed. An interview was conducted with the resident at that time. Observed on their bedside table was a tube of Triad ointment. A review of the medical record revealed no documentation or assessment of R367 to be able to self-administer the Triad ointment. On 2/27/25 at 12:26 PM, the Assistant Director of Nursing (ADON) A (who covered the medical care/questions as the facility's Director of Nursing (DON) was not present for the survey) was interviewed and asked about the Triad ointment observed by R367's bedside and ADON A replied that R367 is unable to apply the ointment to themselves and that the ointment should have been stored in the treatment cart. Medication Carts On 2/27/25 at 8:19 AM, a request for a policy for medication administration was made via e-mail, however; it was not provided by the end of the survey. On 2/26/25 at 12:45 PM, an observation of the [NAME] Hall medication cart #1 was conducted. It was observed the lock was engaged but the top left drawer and the second right drawer were ajar and could be opened without unlocking the cart. At that time, Nurse 'U' came to the cart and was asked to unlock the cart, secure all drawers tightly and re-engage the lock. After doing so, it was observed the right second drawer was then not able to be opened, but the top left drawer could still be opened with the lock engaged. Further review of the cart revealed a Humalog flex pen (generic insulin lispro) with an open date of 12/1/24 and a Lantus (generic insulin glargine) flex pen with no open date. It was also discovered food items (applesauce cups and hot cocoa packets) were stored in the bottom drawer of the cart with medications and the liquid drug disposal system. On 2/26/25 at 1:00 PM, a review of the medication cart #2 on the [NAME] unit was completed with Nurse 'E'. The cart revealed a Novolog flex pen (generic insulin aspart) and a Lantus flex pen with no dates they were placed in the cart. The cart further revealed six cups of applesauce, four cups of pudding and a cup of prune juice stored in the bottom left drawer with resident's oral medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/26/25 at 1:15 PM, an observation of medication cart #1 on the [NAME] unit was conducted with nurse 'V'. The cart revealed three open tubes of diclofenac gel (topical pain relief) stored alongside oral medications in the bottom right drawer. The bottom left draw revealed two cups of applesauce stored with resident's oral medications. On 2/26/25 at 1:20 PM, an observation cart of medication cart #2 on the [NAME] Unit was conducted with Nurse 'W' and the following was observed: a Humalog (generic insulin lispro) flex pen with no date it, had been placed in the cart, two Humalog flex pens in a plastic zipper bag with a green label that read, REFRIGERATE UPON ARRIVAL with neither pen containing a date it had been placed in the cart, a second zipper bag with the green refrigeration label containing an insulin glargine (trade name Lantus) flex pen, a Lantus flex pen, and a Novolog flex pen, none with dates when they had been placed in the cart, and an insulin lispro (trade name Humalog) flex pen with no patient name or date when it had been placed in the cart. At that time, Nurse 'W' said the cart being reviewed was not their usual cart. They were then asked if insulin pens should be labeled and dated and said they should. On 2/27/25 at 9:18 AM, an interview was conducted with the facility's Assistant Director of Nursing and they were asked if the insulin pens should be dated and said they should be refrigerated until they are placed in the cart for use and contain a date of when they were placed in the cart. A review of drug manufacturer's recommendations for insulin storage was conducted and revealed the following: Humalog (generic insulin lispro), Novolog (generic insulin aspart) and Lantus (generic insulin glargine) unopened should be refrigerated at 36-46 degrees Fahrenheit and once opened should be discarded after 28 days. On 2/27/25 at 10:26 AM, Nurse 'K' was requested to observe their medication cart. Upon observation of the medication drawer that contained multiple medication cartridges (with foil backing), there were several loose pills stored on the bottom of the drawer that were green, yellow, blue, and white in color. When asked if they could identify the pills, or who they were for, Nurse 'K' stated I have no idea. They removed the pills with their bare hands, then placed the pills into a clear medication cup and took to the medication room to dispose in a container labeled drug disposal. On 2/27/25 at 2:32 PM, an interview was conducted with the Assistant Director of Nursing (DON). When informed of the concern with the observation of the medication cart with Nurse 'K', they reported that was a frequent problem (with medications in the cartridges) but the carts should be reviewed upon starting to ensure those were maintained.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22960 Based on observation, interview, and record review, the facility failed to prepare food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among all residents that consume food from the kitchen. Findings include: On 2/25/25 between 8:35 AM-9:15 AM, during an initial observation of the kitchen, the following items were observed: In the walk-in cooler, there was dried up milk on the floor underneath the milk crates. The inside bottom shelf of the Victory freezer was soiled with food spills and food debris. On 2/25/25 at 9:00 AM, Corporate Chef Y confirmed the soiled flooring in the walk-in cooler and inside the Victory freezer, and stated they would be cleaned right away. According to the 2017 FDA Food Code section 4-602.13 Nonfood-Contact Surface, Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. The ceiling vent located near the ice machine was coated with dust. According to the 2017 FDA Food Code section 6-501.14 Cleaning Ventilation Systems, Nuisance and Discharge Prohibition, (A) Intake and exhaust air ducts shall be cleaned and filters changed so they are not a source of contamination by dust, dirt, and other materials. The flooring underneath and behind the ice machine was observed with a heavy buildup of trash debris and a black, mold-like substance on the floor tiles. At the hand sink located next to the Southbend skillet, there was a hose hanging on the wall, with a continuous flow of dripping water onto the floor. The floor was wet with a black mold-like substance on the surface of the floor tiles. The flooring underneath the 3 compartment sink was wet, with a black mold-like substance observed on the surface of the tiles. There was a buildup of food debris on the floor underneath the racks in the dry storage room. On 2/25/25 at 12:00 PM, Corporate Chef X stated they haven't had a porter in the kitchen for a while, so while they do mop the floors, they don't get deep cleaned as often as they should. According to the 2017 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions, (A) Physical facilities shall be cleaned as often as necessary to keep them clean. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The trash can for the hand sink located next to the Southbend skillet was heavily soiled on the exterior with black and brown stains. According to the 2017 FDA Food Code section 5-501.116 Cleaning Receptacles, .(B) Soiled receptacles and waste handling units for REFUSE, recyclables, and returnables shall be cleaned at a frequency necessary to prevent them from developing a buildup of soil or becoming attractants for insects and rodents. The floor drain located underneath the soiled drainboard of the dish machine was observed with numerous small drain flies. According to the 2017 FDA Food Code section 6-501.111 Controlling Pests, The PREMISES shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the PREMISES by: .2. (B) Routinely inspecting the PREMISES for evidence of pests; 3. (C) Using methods, if pests are found, such as trapping devices or other means of pest control as specified under SS 7-202.12, 7-206.12, and 7-206.13; and 4. (D) Eliminating harborage conditions. On 2/25/25 at 12:15 PM, Dietary Staff Z was observed measuring the internal temperatures of the food items on the steam table in the [NAME] kitchenette. Staff Z retrieved a thermometer from inside a binder. Staff Z did not sanitize the thermometer probe, and began measuring the internal temperatures the food items on the steam table. Staff Z then took the temperatures of all the food items on the steam table, without ever using a probe wipe to clean the thermometer probe. On 2/25/25 at 12:20 PM, Chef X was queried about the expectation from staff when taking the temperature of food items, and confirmed that the thermometer should have been cleaned with a probe wipe initially as well as in-between each food item.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 30675 Based on interview and record review the facility failed to ensure the facility assessment was reviewed and revised in accordance with current regulatory requirements. This has the potential to affect all 117 residents. Findings include: According to the Centers for Medicare & Medicaid Services (CMS) memo: QSO (Quality Safety & Oversight)-24-13-NH, dated 6/18/2024, revised Facility Assessment requirements effective 8/8/2024 included: .In conducting the facility assessment, the facility must ensure .Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing/ and (ii) Direct care staff, including but not limited to, RNs (Registered Nurse), LPNs (Licensed Practical Nurse)/LVNs (Licensed Vocational Nurse), NAs (Nurse Aide), and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members . On 2/26/25 at 11:10 AM, review of the documentation provided for the Facility Assessment Tool revealed this had last been updated on 1/10/25. Review of the section that identified Persons (names/titles) involved in completing assessment included only the following staff: the Administrator, Director of Nursing, Assistant Director of Nursing, Infection Preventionist, Social Services Director, Dietary manager, Housekeeping/Laundry Manager, and Maintenance Director. There was no documentation included within this facility assessment that identified the facility had obtained active involvement with the Medical Director, direct care staff, and obtained input from residents, resident representatives, and family members. On 2/27/25 at 8:23 AM, an interview was conducted with the Administrator regarding the facility assessment documentation provided and some areas that had questions marks within the document itself. They reported they may have provided a working copy and would submit a revised copy. When asked if they had included any resident and family input into the facility assessment, the Administrator reported they had not yet. When asked if they were aware of the requirements to the facility assessment effective 8/8/24, the Administrator did not give a definitive response but reported that was around the time they started in their role and would have to work on that. When asked if they might have attended any resident council meetings to obtain input, the Administrator reported they had not due to having simultaneous other meetings when resident council was held. On 2/27/25 at 9:00 AM, the Administrator provided an updated facility assessment last updated 1/10/25 which included additional details of the number of direct care staff in their staffing plan. There was no additional documentation provided to address the concerns identified above.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48680 Based on observation, interview and record review the facility failed to ensure enhanced barrier precautions (EBP)policies and protocols were followed and maintained for three residents (R48, 53, & and 78), maintain linen carts, as well as a system of surveillance that consistently documented signs and symptoms of infections and consistently tracked and trended infections, this had the ability to affect all 117 residents residing at the facility. Findings include: Review of the facility's Infection Control program revealed the following: The program revealed no consistent documentation of signs and symptoms and laboratory (Lab) data results for residents with infections that were listed for the months of January 2025 and February 2025. On 2/27/25 at 10:25 AM an interview with the facility's infection control preventionist (ICP) and the Director of clinical services was asked about the missing Lab data and signs and symptoms for the line listing for the months for January and February, and who was responsible for ensuring that all items are completed to finish the monthly surveillance. The ICP nurse replied that they were responsible for ensuring that the surveillance was completed and that required labs were documented and completed. The ICP also stated that for signs and symptoms that they rely on the floor nurse's documentation but if there were not any signs documented then they had nothing to go by. A review of a facility policy titled Surveillance for Infections (Revision date May 2021) documented in part, . Surveillance of infections occurring will be conducted on a regular basis by the infection control preventionist Conditions which meet the McGeer's criteria of infection are considered an infection . The infection preventionist should evaluate each set of signs and symptoms of potential infection . the Infection Preventionist should utilize a facility schematic to assist in identifying facility trends. This will enable the infection control team to identify potential issues of cross contamination from all sources . No addition information was provided by the exit of survey 38271 R53 On 2/25/25 at approximately 10:19 a.m., R53 was observed in the common area, up in their wheelchair. R53 was observed to have a catheter bag hanging from the wheelchair. R53's room was observed to not have any signage for EBP (enhanced barrier precautions). On 2/26/25 at approximately 8:32 a.m., R53 was observed in their room, laying in their bed. R53's room door was still observed to not contain any signage indicating R53 should be provided enhanced barrier precautions while providing direct care or to ensure hands were disinfected prior to entering R53's room. (continued on next page)

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	235477	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pomeroy Living Rochester Skilled Rehabilitation	3500 West South Blvd Rochester Hills, MI 48309

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/26/25 between 8:32 a.m., and 8:36 a.m., three facility staff members were observed entering R53's room without sanitizing their hands prior to entering the room. At that time, the staff members were observed providing direct care to R53. On 2/27/25 at approximately 8:33 a.m., R53's room was still observed without any signage indicating R53 was to be provided EBP while providing care. On 2/27/25 at approximately 11:36 a.m., R53 was observed in their wheelchair by the Nursing station. R53 was observed to have their catheter tubing dragging on the facility floor. On 2/25/25 the medical record for R53 was reviewed and revealed the following: R53 was last admitted to the facility on [DATE] and had diagnoses including Parkinson's disease and Chronic kidney disease. A review of R53's MDS (minimum data set) with an ARD (assessment reference date) of 1/17/25 revealed R53 needed assistance from facility staff with most of their activities of daily living. R53's BIMS score (brief interview for mental status) was three indicating severely impaired cognition. A review of R53's comprehensive plan of care revealed the following: With interventions implemented by the facility, my risk for urinary tract infection due to use of catheter will be reduced through next review Interventions-EBP as ordered .Effective 2/25/2025 . On 2/27/25 at approximately 9:07 a.m., during a conversation with the Infection Control Preventionist (ICP)/ADON, was interviewed pertaining to EBP for R53. The ICP reported that R53 should have had EBP signage on their door indicating staff should be donning EBP while providing care and should be sanitizing their hands prior to entering their room. 30675 R48 On 2/25/25 at 9:10 AM, an interview was conducted with the resident. R48 reported they had been at the facility for about four weeks, but recently had been hospitalized . There was a bandage to their right lower extremity and an urinary catheter drainage bag was secured to the left side of the bed. There was no Enhanced Barrier Precaution (EBP) signage posted on the door, nor was there any personal protective equipment (PPE) available for use. When asked about their wound and urinary catheter, they reported they had those for about four weeks now. Additional observations from 9:15 AM to 12:00 PM revealed staff entering in/out of R48's room without cleaning hands. On 2/25/25 at 11:53 AM, an interview was conducted with Certified Nursing Assistant (CNA 'T') who was assigned to R48. When asked about whether R48 had an indwelling urinary catheter or utilized any infection control precautions, CNA 'T' reported only that the resident was discharging today (which was R48's roommate). When asked if they were sure R48 was discharging today and if it could be their roommate, CNA 'T' reported they needed to go talk with their supervisor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the clinical record revealed R48 was initially admitted into the facility on [DATE], readmitted on [DATE] with diagnoses that included: diabetes due to underlying condition with diabetic neuropathy, Extended spectrum beta lactamase (ESBL) resistance, cellulitis of right and left lower limb, chronic respiratory failure, and lymphedema. According to the MDS assessment dated [DATE], R48 had no communication concerns, had intact cognition, and had an indwelling urinary catheter. On 2/25/25 at 12:04 PM, Unit Manager (UM 'M') approached and stated they were available to answer any questions. When asked about who was in the bed occupied by R48 (as R48 was not included in the documentation provided to the survey team to be in their current room), UM 'M' reported the resident admitted yesterday (the clinical record showed R48 readmitted on [DATE]) and was a readmission. UM 'M' confirmed the resident had a urinary catheter and when asked about the wounds, they reported the resident has cellulitis and has wounds on her legs. When asked if the resident should be on EBP, UM 'M' reported Yes, they should be. They were unable to explain why they had not been implemented. R78 On 2/25/25 at 9:51 AM, R78 was observed lying in bed. There was a urinary catheter drainage bag secured to the side of the bed. The signage posted on the door identified the room was on Enhanced Barrier Precautions and further instructed, .EVERYONE MUST: Clean their hands, including before entering and when leaving the room . There was a cart in the hallway just outside the room that contained several disposable gowns, two N-95 masks and two face shields. There were no disposable gloves, hand-sanitizer, or hand-wipes in the cart, and there was no hand sanitizer on the walls or in the hallway available for use. On 2/25/25 at 9:52 AM, Certified Nursing Assistant (CNA 'S') was observed exiting the room next to R78 and entered into R78's room without cleaning hands (using hand sanitizer, wipes, etc). CNA 'S' was observed to go over to R78's bedside and began moving their bedside tray table around and removed R78's meal tray to return to a cart near the nursing desk. CNA 'S' then re-entered R78's room without cleaning their hands before and upon exiting the room. On 2/25/25 at 10:04 AM, Staff was observed placing a container of Sani-Hands in the top drawer of the cart outside R78's room. Linens: On 2/25/25 at 10:49 AM, the linen cart in the hallway outside of room C54 was observed with scattered candy wrappers and there was a thick white creamy substance spilled directly on top of linen cart material that consisted of a thick mesh-like plastic covering. The inside of this linen cart was observed to have various linens (towels, bed sheets, blue pads, and gowns). Additionally, there were other non-linen items stored directly touching and scattered about which included pink basins, several boxes of disposable gloves that were opened, and various personal care supplies (shampoo, lotion). On 2/25/25 at 10:55 AM, the linen cart across from room A32 was observed to have various linens stored directly touching other non-linen supplies which included clear trash bags, disposable briefs, pink basins, and various personal care items. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/25/25 at 10:57 AM, the linen cart across from room A43 was observed to have various linens stored directly touching other non-linen supplies which included a pink basin with personal care items, several bottles of perineal cleanser, and an opened box of disposable gloves. On 2/25/25 at 11:02 AM, the linen cart across from room A62 was observed to have various linens stored directly touching other non-linen supplies which included disposable briefs, skin repair cream, and two opened boxes of disposable gloves. On 2/25/25 at 11:15 AM, a staff member (wearing maroon colored scrubs) was observed accessing the linen cart outside of room A63, while holding towels, gowns and linens in their arms directly pressed against and in contact with their upper body and proceeded to walk down the hallway. On 2/26/25 at 9:31 AM, a staff member (wearing maroon colored scrubs) was observed exiting the clean utility room and entering room D61 with clean linens that were held directly pressed against and in contact with their upper body. On 2/26/25 at 12:13 PM, an interview was conducted with the Assistant Director of Nursing (ADON) who was currently acting as the interim DON while the DON was out sick. The ADON was also the facility's Infection Preventionist. When asked about the storage of linens, and how they should be transported/held when staff obtained clean linen, the ADON reported all staff were in-serviced upon hire that linens should be held away from them and to consider anything else they might come into contact with as contaminated. The ADON was informed of the concerns with the observations and reported that should not have occurred. When asked what should be stored on/within the linen carts, the ADON reported various linens and mentioned at times the staff might use pink basins that had individual shampoos and things like that. The ADON was informed of the multiple observations of the linen carts from 2/25 - 2/26/25 and was asked to observe a few of the linen carts. Upon observation of the linen cart on [NAME] unit, the ADON confirmed there were various items other than linens, including gloves, pink basin with toiletries, and garbage bags stored within the linens. The ADON reported those would be removed immediately. Upon observation of the [NAME] unit, the ADON confirmed the linen cart contained various items that should not have been stored with the linens, including trash bags and disposable gloves and confirmed those items should not have been stored with the linens.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 48680 Based on interview and record review the facility failed to implement an effective antibiotic stewardship program that included consistent implementation of protocols for appropriate antibiotic use for three (R418, R29 and R97) of three residents. Findings include: R418 A review of R418 record revealed that in the month of January they were started on Keflex (antibiotic) 500 milligrams (mg) twice a day for five days. The physician also ordered labs. There was no documentation of any signs and symptoms for the need for the antibiotic or labs. R418 arrived from the hospital on contact precautions for clostridium difficile (c. diff-an infection of the bowel often caused by the over use of antibiotics) and was prescribed an antibiotic that started 1/6/25 and was supposed to continue for 10 days, however the order was not transcribed correctly upon admission. R29 A review of R29's medical record revealed that in the month of February 2025, they were prescribed ertapenem antibiotic without a start date and that the first dose was not given. R97 A review of R97's medical record revealed that in the month of February 2025, they were started on Keflex for 7 days and was prescribed for 2/17/25. R97 did receive antibiotics for the 7-day duration but the antibiotic was started back on 2/21/22 (a delay in treatment). On 2/27/24 at 10:25 AM, an interview with the facility's infection control preventionist (ICP) and the Director of clinical services was completed. They were asked about what happened with R418 missing labs and why didn't they complete the remaining five days of antibiotics for c. diff and if R29 should have a stop date for the ertapenem and will they receive the missing first dose of antibiotics., and finally for R97, what the signs and symptoms for the restarting of the Keflex were and who prescribed the medication. The ICP replied, that the labs should have been done for R418, and the order was put in incorrectly for c. diff antibiotics. For R29, they should have a stop date, and they would fix the order and will add the first dose that was missed on for an extra day at the end. For R97, the ICP replied they were unsure why the medication was restarted. No additional information was provided by the exit of survey.